Education ~ Early Detection ~ Cure
Complete Women's Imaging PC

990 STEWART AVE SUITE 100
GARDEN CITY NY 11530
516 222 4294 * FAX 516 222 4885
www.completewomensimaging.com

Authorization to Use and Disclose Health Information

(Note: This form cannot be used to authorize a release of HIV related information)

Patient Name: _____ Date of Request: _____

Patient Phone #: _____ Date of Birth: _____ Requested Pick-Up Date: _____

Test Type	Film Origin	Date

Reason for film request: _____

Request Taken By: _____
Print Initial Date

Request Given To: _____
Print Initial Date

MR Review _____
Print Initial Date

Administrative Approval _____
Signature Date

By signing below, I hereby authorize the release or disclosure of my Personal Health Information to the following recipient for the specific purpose of Treatment:

☐ Myself
☐ Other: _____

_____
CWI-Date Picked Up Signature of Designee

☐ Mailed to: _____
Name Address

_____
CWI-Date Mailed Initials

This authorization will remain in effect from the date of this authorization until the request is fulfilled.

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I understand that once the above mentioned films are removed from the CWI, PC practice that CWI cannot be held responsible for any loss or damage that may occur to them.

Name **Signature** **Date**

Submit Form